LTC Residents Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085028	A. BUILDING _____ B. WING _____ APR 13 2010 Director's Office	03/08/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES - WILMINGTON	700 FOULK ROAD WILMINGTON, DE 19803

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F 000	INITIAL COMMENTS An unannounced annual survey was conducted at this facility from February 24, 2010 through March 8, 2010. The deficiencies contained in this report are based on observation, interview, review of residents' clinical records and review of other documentation as indicated. The facility census the first day of the survey was 132. The survey sample totaled 104 residents, which included 40 census residents, 30 admission residents and 34 Stage 2 residents. Additionally, there were 2 subsampled residents.	F 000	**The statements made on this Plan of Correction is not an admission to and do not constitute an agreement with the alleged deficiencies herein.** **To remain in compliance with all Federal and state regulations, the Center has taken or will take the actions set forth in the following Plan of Correction. The following Plan of Correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.**	
F 223 SS=D	483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on observation and review of facility documentation as indicated, it was determined that the facility failed to ensure that one resident (R146) out of 34 was free from verbal and mental/emotional abuse. Findings include: R146 was admitted to the facility on 12/4/08. R146 currently has advanced Alzheimer's dementia. Review of R146's annual Minimum Data Set assessment, dated 12/4/09, listed her cognition as moderately impaired with short and long-term	F 223	**F 223 Free From Abuse/Involuntary Seclusion** **It is the practice of this facility that residents are free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.** **Employee was removed from the Patient care area and was suspended. An investigation was completed and the employee was subsequently terminated.** **Staff was in-serviced on appropriate treatment of residents and reporting of allegations of verbal abuse. (See attachment #1) The Director of Care Delivery or Designee evaluates appropriateness of staff's**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

[signature] RN BSN NHA — ADMINISTRATOR — 4/6/2010

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 223	Continued From page 1 memory impairment. Behaviors and moods included periods of altered perception or awareness of surroundings, periods of restlessness, verbally and physically abusive, socially inappropriate/disruptive behavior and resistive to care. On 2/25/10 at 9:30 AM, this surveyor was in a resident room 3 doors away when she heard E18 (assigned CNA) talking loudly to R146. E18 stated, "she peed all down my leg! I'm definitely taking off tomorrow." Prior to this E18's general tone was loud and argumentative. The surveyor observed R146's bedroom door to the hallway wide open and E18 was talking to R146 in the resident's bathroom with the door ajar. R146 did not sound distressed when E18 made the above statements. The incident was reported by the surveyor to the Nursing Home Administrator (E1) and Director of Nursing (E2) on 2/25/10. E18 was immediately suspended pending investigation and the incident was reported by the facility to the Division of Long Term Care Residents Protection (DLTCRP). Review of the facility's investigation and 5 day follow-up to the DLTCRP included witness statements from E19 (LPN/med nurse) who stated that E18 was angry because she was asked to toilet R146 and E20 (LPN/med nurse) who stated that he was about to tell E18 to stop being so loud with R146 when he observed the surveyor going to R146's room. E20 stated that the resident appeared "OK" when asked by the facility how R146 responded to the comments by E18. The investigation stated, "On 2/25/10, DHSS surveyor heard CNA talking loudly and being "verbally abusive" to resident during toileting. E18	F 223	**communication during Resident's care.** **New employees are in-serviced on signs of abuse and reporting of allegations. Yearly abuse in-service is completed by all employees through the facility's continuing education program. The Division of Long Term Care presents an in-service annually on abuse and mistreatment.** **Facility will continue to investigate reports of alleged abuse and or mistreat ment. Resident interviews will be conducted randomly to evaluate staff treatment of residents.** **ADNS and or designee reviews Incident Occurrences. Director of Care Delivery and or Designee will make patient care Rounds to evaluate treatment of residents. (See attached #2)** **Results of patient care rounds will be reviewed by the Quality Assessment & Assurance Committee monthly. The Quality Assessment & Assurance Committee will determine the need for further actions.** 4/6/10	

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F 223	Continued From page 2 was terminated on 3/1/10 following facility investigation.	F 223		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation and record review, it was determined that the facility failed to ensure that a comprehensive care plan was developed for one resident (R221) out of 34 sampled. While the facility initiated a care plan for R221's dialysis catheter (central catheter in the chest), the care plan failed to identify the risk of bleeding from the catheter and that a clamp should be kept at the bedside in case of bleeding. Findings include:	F 279	**F 279 Comprehensive Care Plans** **It is the practice of the facility to use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. It is the practice of the facility to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. It is the practice of the facility that the care plan describes the services that are furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under 483.25; and any services that would otherwise be required under 483.25 but are not provided due to the resident's exercise of rights under 483.10, including the right to refuse treatment under 483.10 (b) (4).** **Resident # 221's care plan was revised to include clamps to be kept at bedside.**	

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F 279	Continued From page 3 While the facility initiated a care plan for the potential for complications at the intravenous insertion site (right chest dialysis catheter), they failed to identify a risk for bleeding from R221's dialysis catheter and failed to identify the intervention that a clamp should be kept at her bedside in case of bleeding. Additionally, R221 was also on Aspirin which placed her at even higher risk of bleeding. Observations on 3/2/10 revealed lack of a clamp at R221's bedside.	F 279	**Dialysis residents having a permacath or Sheldon catheter were identified for clamps at the bedside. Care plans were revised to include clamps at the bedside.** **Patients with permacaths or Sheldon catheters will be identified in the morning meeting. Director of Care Delivery or Designee will perform audits of patients with permacaths or Sheldon Cathers to evaluate whether clamps are at the bedside and care plans are revised to include clamps at the bedside.** **Results of the Hemodialysis Audit will be reviewed by the Quality Assessment and Assurance Committee monthly. The Quality Assessment and Assurance Committee will determine the need for further audits or action plans. (See attached #3).** **F280 Right to Participate in Care planning- revise Care plan** **It is the practice of the facility to allow the resident/interested family member to participate in the planning of care and treatment or changes in care and treatment with the appropriate members of the Interdisciplinary team.**	4/6/10
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by:	F 280		

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F 280	Continued From page 4 Based on clinical record review, observation, and resident and staff interviews, it was determined that the facility failed to ensure that 2 resident's (R155 and R166) out of 34 sampled and/or family members to the extent practicable, were given the opportunity to participate in planning care and treatment. The facility failed to have quarterly care plan conferences for R155's and R166's family members with the interdisciplinary care team members other than one to one briefings with the Unit Director (E10). While specific examples listed here are for two residents E10 confirmed that this was her practice in the Arcadia Unit with an approximate census of 20 residents. Findings include: 1. Resident 155 had diagnosis of severe dementia and resided in the facility's Alzheimer's unit. During an interview with a family member on 3/1/10 at approximately 1:00 PM, he acknowledged that he was never invited to attend a group/Interdisciplinary Team (IDT) care plan meeting. This family member was not aware that there were quarterly care plan meetings held that included the resident and/or interested family member. He stated that he usually gets some care/treatment briefings from E10 (Arcadia unit director) when he comes to visit. Review of R155's clinical record revealed this residents's care conference form dated 8/21/09 was signed by this family member and E10 indicating that he was briefed by the Unit Director. The care conference form dated 12/29/09 had missing information of attendance by members of the IDT team involved such as Nursing, activities, dietary social services and a family member. The	F 280	**Resident R155's family was invited to participate in a care planning meeting with the IDT team on 3/26/2010. Resident R166's family was invited to participate in a care** **planning meeting with the IDT team on 3/8/2010.** **The Arcadia Director was re trained on the facility protocols for the team meetings, and the need to capture signatures of the participating members. A master care plan calendar was developed on 3/23/2010 for the Arcadia Unit, and the IDT team was copied on this calendar.** **The NHA and Arcadia Director will monitor weekly compliance with the IDT meetings and attendance. (See attached #4)** **Results of the IDT documentation monitoring audit will be reviewed by the Quality Assessment and Assurance Committee monthly. The Quality Assessment and Assurance Committee will determine the need for further audits or action plans.**	4/6/10

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F 280	Continued From page 5 clinical record failed to indicate that a meeting was held between members of the IDT team and family member. On 3/01/10, E10 acknowledged that she briefed R155's interested family member when he came to visit about the resident's condition/care. E10 also acknowledged that she did not send invitations to R155's family member specifically to attend a quarterly care plan conference. Additionally, E10 indicated that she was not aware that quarterly care plan conferences on her unit were to be attended by members of the IDT. In an interview with E12 (Registered Nurse Assessment Coordinator- RNAC) on 3/3/10 at 2:00 PM she confirmed that specifically in the 3 units (New Castle, Dover and Heritage) where she was involved residents' care plan meetings were done quarterly in coordination with the completion dates of the MDS assessments. She stated that invitations were sent to the families/residents. The Social Worker was responsible for sending the invitations and/or RNAC, if the Social Worker (SW) was not in the facility. Members of the IDT consisted of the SW, dietitian, Occupational, Physical and Speech Therapists, activities and Directors of Care from the different units. In an interview with E1 (Administrator) on 3/4/10 at 1:30 PM, she acknowledged that the Arcadia unit, invitations should be send to the families since residents' cognitive abilities were severely impaired. The facility failed to ensure that family members of residents with impaired decision-making skills participated in the care planning process with the	F 280		

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F 280	Continued From page 6 appropriate IDT members. 2. During an interview with R166's wife on 2/24/10, she stated that R166 had been on Arcadia, a locked dementia unit, for about 2 years. When asked if she attended quarterly care plan meetings or received invitations to them, she stated, "no." R166's wife stated she was periodically updated on her husband's condition by the Unit Director (E10). Review of care plan conferences from 3/09 through 2/10 contained signatures of only R166's wife and E10. There were no signatures of other disciplinary team members such as dietary or activities. E10 confirmed findings on 3/3/10. E10 stated she did not know that other disciplines were supposed to be present at care plan meetings.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other documentation as indicated it was determined that the facility failed to meet professional standards of quality for one resident (R221) out of 34 sampled. The facility failed to have a spare clamp available at R221's bedside in case of bleeding from her multilumen dialysis catheter. Findings include:	F 281	**F 281 Services Provided Meet Professional Standards** **It is the practice of this facility that services provided or arranged by the facility will meet professional standards of quality** **Resident #221's clamp for catheter was placed at bedside.**	

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F 281	Continued From page 7 Record review revealed that R221 was admitted to the facility on 10/29/09 with diagnoses including end stage renal disease with hemodialysis. R221 had a 4 lumen dialysis catheter (Permcath) in her right chest used for hemodialysis (done in outside facility). Care plan review revealed that R221 was on Aspirin which increased her risk for bleeding. Review of Bard instructions for use of "Hickman* Hemodialysis/ Apheresis Long Term Central Venous Catheters", revised July 2007, stated, "... Patient Information- Catheter Care and Maintenance... (page 27) You should always clamp your catheter whenever it is opened to the air, such as during catheter cap changes, or when connecting intravenous infusions to your catheter. Always have a spare clamp available." Although R221 had a Permcath catheter in place, it is similar to a Hickman catheter in that they are both tunneled catheters used for dialysis, however, the Permcath is larger and stronger than a Hickman catheter. Observations on 3/2/10 revealed lack of a clamp at R221's bedside. E16 (nurse supervisor) confirmed on 3/2/10 that there was no clamp at the resident's bedside. She stated there were clamps in the locked medication room on the same floor, but there should have been one in R221's room accessible to everyone. E22 (CNA) was interviewed on 3/2/10. E22 stated that she had never seen a clamp in R221's room before now. A spare clamp was observed taped to the side of R221's closet next to her bed after interview with E16. E22 further stated that the	F 281	**Residents with Permacaths or Sheldon catheters were evaluated for clamps at bedside.** **In-servicing was completed to nursing staff for the need of clamps at bedside on patients with Permacaths or Sheldon catheters. (See attached #5)** **Director of Care Delivery or designee will audit to evaluate whether clamps are at bedside for residents with Permacaths or Sheldon catheters.** **Results of the Hemodialysis audit will be reviewed by the Quality Assessment and Assurance Committee monthly. The Quality Assessment and Assurance Committee will determine the need for further audits or action plans. (Refer to attachment # 3)**	4/6/10

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F 281	Continued From page 8 facility had reviewed the use of clamps with the CNA's recently.	F 281		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, it was determined that the facility failed to ensure that 1 (one) resident (R164) out of 34 sampled received appropriate treatment and services to restore as much normal bladder function as possible. Findings include: R164 had diagnosis that included hypertension (HTN), urosepsis, osteoarthritis (OA) and diabetes mellitus (DM). According to R164's quarterly Minimum Data Set (MDS) assessment dated 12/8/09, her cognitive skills for daily decision making were "modified independence-some difficulty in new situations only" and she had no short term or long term memory problem. R164 needed extensive assistance of staff in her activities of daily living (ADLs) that included transfer to/from bed, chair, wheelchair and standing position (used stand up lift assisted by 2 people), on and off the toilet,	F 315	**F 315 No Catheter, prevent UTI, Restore Bladder** **It is the practice of the facility to ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract Infections and to restore as much normal bladder function as possible.** **Resident # 164's toileting program was evaluated and revised to meet resident's needs on 3/8/2010.** **Residents on a toileting program were evaluated for adjustments that needed to be revised to meet their individualized needs.**	

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F 315	Continued From page 9 commode and bedpan. R164 was assessed as frequently incontinent of bladder (coded as 3 in the MDS). It was observed during the survey period that R164 used a wheelchair and wheeled herself around the unit. The facility initiated a care plan dated 6/5/08 (last reviewed on 12/29/09) for "Urinary incontinence related to Disease Process, DM(diabetes mellitus), weakness and decrease mobility". The interventions included "...Adjust toileting times to meet patient needs" and "Individual Toileting Plan". In an interview with R164 on 3/4/10, she stated that she had control of her bladder, however, if she had to wait 30 minutes to an hour after she called for assistance, she stated "I will wet my pad especially in the evening shift or night shift ". She also stated that she experienced wetting her adult protective garment whenever she sneezed or coughed (stressed incontinence due to increased intra-abdominal pressure). On 3/8/10 at approximately 8:30 AM, R164 was observed sitting on the side of her bed eating breakfast. She stated that the CNA offered to toilet her before the breakfast tray was served. She refused because she didn't feel like she had to use the toilet. When she started to eat her breakfast, she began to have the urge to use the bathroom but decided not to call the staff. She stated "I did not want to bother them" and she wet her adult protective garment instead. Review of R164's daily record of "Incontinent Management-Maintenance Program"(documented record of her scheduled daily toileting) from 10/09 through 4/4/10 indicated	F 315	**Appropriate Resident's bladder patterning and analysis worksheet will be evaluated upon admission. (See attachment #6) An individualized toileting program will be initiated if applicable. An audit of resident's on a toileting program will be done to evaluate individualized needs on plan of care.** **Results of the toileting program audit will be reviewed by the Quality Assessment and Assurance Committee monthly. The Quality Assessment and Assurance Committee will determine the need for further audits or action plans. (See attached #7)**	4/6/10

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F 315	Continued From page 10 that R164 was toileted "upon arising, breakfast, lunch, dinner, bedtime (HS) and PRN (as necessary)". However, there were no specific times identified when to toilet the resident. For example, an hour prior to each meal and/or within 30 minutes after meals and included alternative devices available to use such as bed pan/commode at bedtime and PRN (as necessary) in place of the stand up lift. The toileting care documentation indicated that R164 was mostly continent of bladder on the 7-3 PM shift but mostly incontinent on the 11-7 AM and 3-11 PM shifts. Review of R164's clinical record revealed that the facility had no record of a voiding pattern assessment completed when she was first admitted to the facility to identify her voiding patterns on all shifts. Interview with E8 (RN-Staff Development) and E9 (LPN) on 3/4/10 acknowledged this finding. Even though R164 was placed on a toileting program, there was no system/procedures put in place to monitor and analyze results/patterns of this resident's toileting care program to identify decline or improvement of her bladder function. CNA documentation indicated that the resident was more incontinent specifically on the 11-7 AM shift and 3-11 PM shift. There was lack of documented evidence that the facility adjusted this resident's toileting times to meet patient needs as indicated in R164's care plan. During an interview with R164 on 3/8/10 at approximately 9:35 AM, with E7 (ADON-RN), R164 expressed her time preferences/needs on toileting. For example after meal times and	F 315		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES - WILMINGTON	700 FOULK ROAD WILMINGTON, DE 19803

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F 315	Continued From page 11 especially after being offered and drinking large cups of coffee/fluids in the afternoon. In addition, she was concerned about whether her medication predisposes her to have the urge to urinate more often. During this interview, R164 acknowledged that she was not aware that following her scheduled toileting plan was essential to manage her incontinence and to restore as much of her bladder function as possible. Additionally, on 3/8/10 at approximately 8:45 AM, in an interview with E11(CNA) and E7 (ADON), it was revealed that E11 was not aware of the importance of following the toileting schedule in relation to improving the resident's bladder function. The facility failed to have a system/procedure in place to manage R164's urinary incontinence and to restore/improve as much of her bladder function as possible.	F 315	**F323 free of Accident Hazards** **It is the practice of the facility to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.**	
F 323 SS=B	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations during the environmental tour with maintenance and environmental staff, it was determined that the facility failed to maintain an environment free from accident hazards as	F 323	**The New Castle Clean Utility supply room was immediately secured by the Maintenance Director on 3/3/2010.** **This supply closet was the only room that had not yet been converted to a keyless system. On 3/24/10 this door lock was switched to the keyless system to assure that the self closing door would lock automatically.** **The Maintenance Director and NHA conducted a tour of all areas/closets on 3/24/2010, to determine if there were any other areas requiring a self**	

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F 323	Continued From page 12 evidenced by an unlocked supply room. Finding includes: Observation on 3/3/10 at 11:00 AM of the first floor New Castle clean utility supply room on a tour with E4 (Maintenance Director) and E5 (Environmental Director) revealed the door to be open and contents accessible to residents. The contents observed were: perineal cleansers, Secura personal cleansers, (2 bottles on counter and approx 10 inside cabinets), Provon shampoo (~10), and body wash (~10). E4 and E5 staff confirmed that the door should be locked.	F 323	**locking system. An order was placed to secure three additional keyless locks. These will be installed on or before 4/6/10. The facility will continue to monitor the security of the supply closets during daily routine rounds. Issues will be corrected when identified, and reported to the Maintenance Director via the work order book. Any trends that are identified will be reported monthly at the Quality assessment and Assurance Committee** **The Quality Assessment and Assurance Committee will determine the need for further audits or action plans.**	4/6/10
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that the facility failed to ensure that one (1) resident (R79) out of 34 sampled maintained acceptable parameters of nutritional status. The facility failed to administer Glucerna (supplement) to R79, who was to receive it due to	F 325	**F 325 Maintain Nutrition Status Unless Unavoidable** **It is the practice of the facility to ensure that a resident (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible (2) Receives a therapeutic diet when there is a nutritional problem** **Resident #79 no longer resides at facility-**	

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F 325	Continued From page 13 poor oral intake. Findings include: R79 was readmitted to the facility post hospitalization on 2/13/10 and had diagnoses that included diabetes mellitus, congestive heart failure and atherosclerotic heart disease. The Medicare 5-day assessment, dated 2/20/10, indicated that R79 required supervision and setup help only while eating. The Registered Dietitian's (RD) note, dated 2/15/10, stated that the resident's oral intake was decreased and that Glucerna would be ordered as a supplement to provide additional calories and protein. On 2/15/10 a physician's order was written for R79 to receive Glucerna 1.2 120cc bid (twice a day). A care plan was developed on 2/15/10 for the problem of alteration in nutritional status related to decreased PO (by mouth) intake which included the approach, "Glucerna 1.2 120cc bid (twice a day)." Although the order for the Glucerna was noted by a nurse on 2/15/10 at 3:40 PM, it was never transcribed onto the medication administration record (MAR). Additionally, the facility did not complete a 24 hour chart check (process in which the 11 PM - 7 AM shift checks orders written in the preceding 24 hours) thereby failing to identify the omission of the Glucerna on the MAR. Review of R79's weight record revealed that the resident did not experience any weight loss during this time period. During an interview with E14 (nurse) and E15 (RD), they acknowledged that the Glucerna had not been transcribed onto the MAR and that R79 had not received it from 2/15/10 through 2/25/10.	F 325	**A list of residents receiving supplements was obtained. Medication Administration Records were evaluated against the list for transcription of supplements.** **Nutritional Supplement orders will be read in the morning meeting. The Director of Care Delivery or designee will audit the medication administration record for transcription of nutritional supplements and completion of twenty four hour chart checks.** **The results of the audit will be reviewed by the Quality Assessment and Assurance monthly. The Quality Assessment and Assurance committee will determine the need for further audits or action plans. (See attached #8)**	4/6/10
F 364	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR,	F 364		

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F 364 SS=E	Continued From page 14 PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on temperature readings of a test tray and interview, it was determined that the facility failed to serve food that was palatable and at the proper temperature. Findings include: During the tour of the facility on 2/23/10, R164 complained that food served during meal times was cold. On 3/3/10 at the first floor activity dining room, observations and a test tray were performed during lunch time. The following were observed at 12:00 PM prior to the arrival and serving of lunch from the steam table: a. Four (4) oz milk boxes were found in a container on top of the sink without sufficient ice to keep it cold. The container was left standing for approximately 30 minutes at room temperature before it was served. A sample of the milk was tested with a resulting temperature of 62 degree Fahrenheit (acceptable temperature range is 41 degrees Fahrenheit). b. The little boxes of creamer were 70.71 degrees Fahrenheit and there were about 20 creamers. During an interview with E13 (Food Service Worker) on 3/2/10, he acknowledged that the milk should have been brought to the dining area when they were ready to serve food.	F 364	**F 364 Palatable/preferred temperatures** **It the practice of this facility to provide food prepared by methods that conserve nutritive value, flavor, and appearance; and that food is palatable, attractive, and at the proper temperature.** **The FSD discarded the milk and creamers when the isolated situation was identified. New milk and creamers were obtained from the kitchen and served to the residents. The food service worker was counseled about the breach of procedure for delivery of milk/creamers to the dining room. The resident R164 was offered a new bowl of soup and declined. The food service worker was counseled about the breach in procedure for the serving of soup from the steam table rather than pre-poured bowls. (See attached #9)** **The FSD altered the delivery method for the milk products- thereby assuring that milk products were separated from soda products that did not need to be kept cold. The**	

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F 364	Continued From page 15 R164 was waiting for her lunch when she was served a bowl of soup. After she tasted the soup, she complained that her soup was cold and refused to eat it. The temperature of the soup when tested was 111 degrees Fahrenheit (acceptable range was 140 degrees Fahrenheit). In an interview with E6 (Food Manager) on 3/2/10 at approximately 12:55 PM, he acknowledged that the soup should have been in the steam table. The facility failed to ensure that the food served was palatable and at a proper temperature.	F 364	**food service staff was retrained on the process and methods in use for the Social Dining Room. (See attached # 10)** **The FSD developed a checklist to be used by the cook prior to food/beverages leaving the kitchen for delivery to the Social Dining Room. (See attached # 11)** **This monitoring checklist audit will be reviewed by the FSD weekly. The FSD will present findings to the Quality and Assurance Committee monthly. The QAA committee will determine the need for further audits or action plans.**	4/6/10
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425	**F 425 Pharmaceutical Services-Accurate Procedures** **It is the practice of the facility to provide pharmaceutical services that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biological to meet the needs of the residents.**	

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F 425	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that pharmaceutical services provided met the needs of each resident. Findings include: 1. On 3/3/10, during observation of the second floor medication room/refrigerator with E17 (LPN) the following expired medications were found: 2 vials of influenza vaccine (biological products) expiration date 7/09, 1 (one) intravenous Tobramycin (antibiotic medication) expiration date 2/5/10 and Diflucan (antifungal medication) 10 mg suppository expiration date 2/19/10. E3 (RN) also confirmed this finding on 3/3/10. The facility failed to ensure that these medications/biological products were disposed of to ensure residents' safety. 2. During a random check of medications (meds) in the first floor medication room on 3/3/10, unopened stock bottles of 1,000 buffered Aspirin 325 mg. and 60 Cerovite Jr. (multivitamin with minerals) were found with expiration dates of 10/09. Findings were confirmed with E19 (LPN/med nurse). E19 stated that meds kept in the med room were not routinely checked for expiration dates, but nurses were responsible to check for expiration dates prior to placing stock meds in their med carts. The facility failed to have a system in place to ensure medications were reviewed for expiration dates.	F 425	**The expired meds were removed from the back up supply in the medication rooms immediately upon identification.** **A sweep of all the med rooms and med carts was completed on 3/3/10 by the ADNS, ADON, Staff Developer, and DCD's. No further issues were identified.** **The facility has switched to ordering a smaller multi-dose supply of Aspirin and Multivitamins. This will help reduce the likelihood that stock over-the counter- meds will expire prior to opening/use. The staffs responsible for retrieving the stock OTC meds were in serviced on proper stock rotation including First in- First out rules. (See attached #12) The facility has increased to frequency of the med room audits for expired meds to weekly rather than monthly. The DCD/designee will complete the audit tool.** **The results of the med room audits will be reviewed by the Quality Assessment and Assurance monthly. The Quality Assessment and Assurance committee will determine the need for further audits or action plans. (See attached #13)**	4/6/10

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F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined that the facility failed to ensure that the resident call system was functioning in two resident rooms (R15 and R149) out of 40 rooms reviewed. Findings include: 1. Observation of R149's call bell on 3/3/10 at 12:35 PM with E4 (Maintenance Director) and E5 (Environmental Director) revealed that the call bell was malfunctioning (overhead light did not light up, no sound, or system did not alarm at nurses station's panel). E4 was observed contacting another maintenance staff to repair the call bell system. On 3/8/10, interview with E4 revealed that the call bell for R149 was repaired the same day and required replacement of the cord attached to the wall. Interview with E4 on 3/8/10 revealed that they conduct monthly checks of all call bells. Evidence of weekly random room call bell checks was not available or provided. Only the January 2010 log of call bell monthly checks was available and reviewed. Review of nursing procedure entitled "Call Light" on 3/5/10 revealed the procedure indicated to "Check lights daily when providing care to ensure that cord length appropriate and that light in	F 463	**F463 Resident Call System-rooms/toilet/bath** **It is the practice of the facility to assure that our Nurses stations are equipped to receive resident calls through a communication system from resident rooms and toilet and bathing facilities.** **R149 and R15's call bells were replaced immediately upon the identification of the issue.** **The Maintenance Director and assistant conduct a thorough monthly check of the call system. Nursing staff evaluate the placement and function of the call bell during the provision of care. Nursing staff were in serviced on the use of the maintenance work order book to document any issues they had with a call bell during their shift, even if they resolved the issue. (See attached #14) This will enable the maintenance staff to perform a follow up check on that light the next day.** **Maintenance will perform 3 random call lights checks per unit weekly as a means of capturing non reported issues earlier. (See attached #15)**	

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F 463	Continued From page 18 working condition". 2. On 2/25/10 at 9:48 AM, R15's bedside call bell was observed to be non-functional. Findings were confirmed with E21 (LPN) and she subsequently contacted maintenance. The call bell was replaced by maintenance within a few minutes. Although staff interviews indicated that R15 was incapable of activating his call bell, staff and/or visitors in need of activating R15's call bell system for assistance would have been unable to do so.	F 463	**The results of the audit will be reviewed by the Quality Assessment and Assurance monthly. The Quality Assessment and Assurance committee will determine the need for further audits or action plans.**	4/6/10
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Cross-refer to F315 Based on clinical record review and interview, it was determined that the facility failed to ensure that one (1) (R164) out of 34 clinical records was complete and accurately documented. Findings include: Resident 164's "Incontinent Management-Maintenance Program", a record of	F 514	**F 514 Res Records-Complete/Accurate/Accessible** **It is the practice of the facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.** **It is the practice of the facility that the clinical record contain sufficient information to identify the resident' a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.** **Resident #164's record has been revised to include individualized plan of care.**	

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F 514	Continued From page 19 her toileting scheduled program from 10/09 through March 4, 2010 did not contain sufficient documentation specifically the 3-11 PM shift to provide sufficient information necessary to identify the resident's toileting improvements or decline. Interview with E8(RN) and E9 (LPN) on 3/4/10 acknowledged this finding.	F 514	**The Director of Care Delivery or designee will review the toileting program worksheets to evaluate documentation.** **The Certified Nursing Assistants have been in-serviced on principles and guidelines of documentation on the toileting plan worksheets. (See attached #16)** **The Director of Care Delivery or designee will audit the toileting plan worksheets weekly to evaluate documentation. (Refer to attachment #7)** **The results of the audit will be reviewed by the Quality Assessment and Assurance Committee monthly. The Quality and Assurance Committee will determine the need for further audits or action plans.**	4/6/10

DELAWARE HEALTH
AND SOCIAL SERVICES
Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Manor Care Wilmington

DATE SURVEY COMPLETED: March 8, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual survey was conducted at this facility from February 24, 2010 through March 8, 2010. The deficiencies contained in this report are based on observation, interview, review of residents' clinical records and review of other documentation as indicated. The facility census the first day of the survey was 132. The survey sample totaled 104 residents, which included 40 census residents, 30 admission residents and 34 Stage 2 residents. Additionally, there were 2 subsampled residents.	The statements made on this plan of correct are not an admission to and do not constitu agreement with the alleged deficiencies her To remain in compliance with all federal an regulations the center has taken or will take set forth in the following plan of correction. The following plan of correction constitute allegation of compliance. All alleged defici have been or will be corrected by the date **Please cross reference the Federal 2567**
3201	**Skilled and Intermediate Care Nursing Facilities**	
3201.6.0	**Services To Residents**	
3201.6.1	**General Services**	
3201.6.1.1	**The nursing facility shall provide to all residents the care necessary for their comfort, safety and general well-being, and shall meet their medical, nursing, nutritional, and psychosocial needs.**	

Provider's Signature Maureen Blunt RHA Title ADMINISTRATOR Date 4/6/2010

Maureen Blunt RHA ADMINISTRATOR 4/6/2010

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	This requirement is not met as evidenced by: Cross-refer to CMS 2567-L, survey date completed 3/8/10, F281, F315, F323, F325, F364, F425 and F514.	Refer to Ftag 281,315,323,325,364,425 & [illegible]
3201.6.5	**Nursing Administration**	
3201.6.5.6	**A comprehensive care plan shall be developed to address medical, nursing, nutritional and psychosocial needs within 7 days of completion of the comprehensive assessment. Care plan development shall include the interdisciplinary team that includes the attending physician, an RN/LPN and other appropriate staff as determined by the resident's needs. With the resident's consent, the resident, the resident's family or the resident's legal representative may attend care plan meetings.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L, survey date completed 3/8/10, F279 and F280.	Plerase refer to Ftag 279,280.
3201.7.0	**Plant, equipment and Physical Environment**	

NAME OF FACILITY: Manor Care Wilmington

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3201.7.3 3201.7.3.4	**Facility Systems Requirements** **The facility shall be equipped with a resident call system which meets the current standards of the Guidelines for Design and Construction of Health Care Facilities. An intermediate care facility serving only developmentally disabled residents shall be exempt from this regulation.** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L, survey date completed 3/8/10. F463.	Please cross reference FTAG 463
16 Del. C., Chapter 11, Subchapter II, § 1121	**Patient's rights** **It is the intent of the General Assembly, and the purpose of this section, to promote the interest and well-being of the patients and residents in sanitoria, rest homes, nursing homes, boarding homes and related institutions. It is declared to be the public policy of this State that the interest of the patient shall be protected by a declaration of a patient's rights, and by requiring that all facilities treat their patients in accordance with such rights, which shall include but not be limited to the following:** (24) Every patient and resident shall be free	

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	from verbal, physical or mental abuse, cruel and unusual punishment, involuntary seclusion, withholding of monetary allowance, withholding of food and deprivation of sleep. **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 3/8/10, F223.	**Please cross reference Ftag 223**